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DSRIP DY7-8

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Overview*

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- Key Changes to the Program Funding and Mechanics (PFM) Protocol
- Overview of Measure Bundle Protocol
  - Category B: System Definition
  - Category C: Selection, Valuation, and Eligible Denominator Populations
- Estimated Timeline
- Questions

* All proposals are contingent on the outcome of CMS negotiations.

Key Changes to PFM Protocol

Based on stakeholder feedback and leadership direction, HHSC made changes to the following:

- RHP Plan Update Submission Timeline
- Category Funding Distribution, including the Private Hospital Participation Regional Incentive
- Costs and Savings Requirement
- Category C Requirements, including the Minimum Point Threshold (MPT)
- Remaining Unused Funds
- Reporting and Carryforward

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RHP Plan Update

- HHSC updated the RHP Plan Update due date from November 30, 2017, to January 31, 2018.
- This allows additional time for Performing Providers to review CY2017 baseline data if they prefer prior to selecting Measure Bundles and no longer overlaps with October DY6 reporting.
- The targeted HHSC approval date remains as March 31, 2018.

Category Funding Distribution

- HHSC shifted 20 percent of a Performing Provider's total valuation for demonstration year (DY) 7 from Category C to submission of the RHP Plan Update.
- The private hospital participation regional incentive was also increased from a maximum of 10 percent of total valuation in Category D to 15 percent.

	DY7	DY8
RHP Plan Update Submission	20%	NA
Category A	0%	0%
Category B	10%	10%
Category C	55 or 65%	75 or 85%
Category D	15 or 5%	15 or 5%

Costs and Savings

- HHSC limited the Category A - Costs and Savings requirement to Performing Providers with a total valuation of $1 million or more per DY.
- These Performing Providers must select at least one core activity of the Performing Provider's choice to submit costs and forecasted or generated savings.

Category C Requirements

- HHSC added optional measures to Measure Bundles rather than requiring all measures within a bundle to be reported.
- Performing Providers have flexibility in distributing valuation among Measure Bundles/Measures as described in the PFM.
- Selected Measure Bundles/Measures must meet minimum denominator size requirements.
- Performing Providers must select at least one "standalone" Measure Bundle or "standalone" measure (3 point measure).
- Delayed and shortened baseline measurement periods may be requested and subject to HHSC approval.

MPT Calculation

- A Performing Provider's MPT is calculated based on:
  - DY7 total valuation
  - Standard point valuation of $500,000
  - MPT cap of 75 for hospitals and physician practices
  - MPT cap of 40 for community mental health centers (CMHCs) and local health departments (LHDs)
  - Medicaid and uninsured inpatient days and outpatient costs (hospitals only)

Remaining Unused Funds

- Based on HHSC review of stakeholder feedback and leadership direction, the remaining unused funds are allocated to RHPs that did not fully utilize their original regional allocation.
- These RHPs may determine how to allocate the additional funds to new and existing Performing Providers based on the community needs assessment.
  - Each RHP must conduct at least 2 public stakeholder meetings.
  - Each Performing Provider must certify that there is IGT for the additional funding.

RHP	Additional Regional Allocation per DY
RHP 1	$866,635
RHP 2	$2,308,000
RHP 4	$522,345
RHP 5	$4,797,112
RHP 8	$5,739,571
RHP 17	$9,284,861
RHP 18	$1,318,286
RHP 20	$4,062,821
TOTAL	$28,899,632

MLIU PPP Reporting

- Category B - Medicaid and Low-income or Uninsured (MLIU) Patient Population by Provider (PPP) may be reported in the last reporting period of each DY or the first reporting period of the next DY.
  - For example, DY7 MLIU PPP may be reported in DY7 Round 2 - October 2018 or DY8 Round 1 – April 2019.
- The MLIU PPP requirement is to maintain or increase the number of MLIU individuals. HHSC removed the previous MLIU PPP requirement to maintain the ratio of MLIU individuals to total individuals.

Category C Carryforward

- Carryforward of achievement was added:
  - DY7 goal achievement may be achieved in PY1 or PY2.
  - DY8 goal achievement may be achieved in PY2 or PY3.
  - The carried forward achievement must be reported in the first reporting period after the end of the carried forward measurement period.
  - For measures with a delayed baseline measurement period, DY8 carried forward goal achievement may be reported in DY9.

DY7-8 Reporting

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	Category A	Category B	Category C					Category D
			P4P Measures				P4R Measures	
DY7 Apr			DY7 Baseline - CY17					DY7 Category D
DY7 Oct	DY7 Category A	DY7 MLIU PPP				DY7 Delayed Measurement Period (DMP) Baseline - ends by 9/30/18	DY7 RY1 Measure	
DY8 Apr				DY7 Goal Achievement - PY1 CY18				DY8 Category D
DY8 Oct	DY8 Category A	DY8 MLIU PPP					DY8 RY2 Measure	
DY9 Apr				DY7 Carryforward Goal Achievement - PY2 CY19	DY8 Goal Achievement – PY2 CY19			
DY9 Oct								
DY10 Apr					DY8 Carryforward Goal Achievement - PY3 CY20			

DY7 or DY8 DMP Goal Achievement - PY2 ends by 9/30/19

DY8 DMP Carryforward Goal Achievement - PY3 ends by 9/30/20

Overview of Measure Bundle Protocol

- Category A: Core Activities, Alternative Payment Models, Costs & Savings, Collaborative Activities
- Category B: System Definition*
- Category C: Measure Bundles*
- Category D: Population-Focused Improvements

*Today's webinar focuses on Categories B&C

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Category A

Category A

Reported during the second reporting period of each DY to be eligible for payment for Categories B-D:

- Core Activities
- Alternative Payment Methodologies (APM)
- Costs and Savings
- Collaborative Activities

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Category B

System Definition

- A participating provider's system definition is intended to reflect the universe of patients served by a performing provider and should incorporate all components of its organization that serve patients.
- There are required and optional components of a performing provider's system definition for each provider type participating in DSRIP.
- The required components are considered essential functions and/or departments of the provider type, what is referred to in the PFM as "base unit."

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System Definition

- Required components must be included in a performing provider's system definition if the organization has that business component.
- Optional components may be added to the system definition and Category B patient count, including contracted partners and "other".
- Providers should consider data availability when defining their system definition.

Draft System Components (Pt 1)

	Required*	Optional
Hospitals	Inpatient Services	Contracted Specialty Clinics
	Emergency Department	Contracted Primary Care Clinics
	Owned Outpatient Clinics	School-based Clinics
	Maternal Department	Contracted Palliative Care Programs
	Homeless Program	Contracted Mobile Health Programs
	Urgent Care Clinics	Other
Physician Practices	Owned or Operated Primary Care Clinics	Contracted Specialty Clinics
	Owned or Operated Specialty Care Clinics	Contracted Primary Care Clinics
	Owned or Operated Hospital	Contracted Community-based Programs
		Other

* Required only if the performing provider has the business component.

Draft System Components (Pt 2)

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	Required*	Optional
Community Mental Health Centers	State-funded Community Hospital	Home-based services
	Community Institution for Mental Disease (IMD)	Contracted Clinic
	General Medical Hospital	School-based Clinic
	Hospital	Other
	Office/Clinic	
	State Mental Health Facility	
	State Mental Retardation Facility	
Local Health Department	Clinics	Mobile Outreach
	Immunization Locations	Other

* Required only if the performing provider has the business component.

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Category C

Category C Agenda

- Category C Menu Development
- Category C Selection Requirements
- Category C Valuation Requirements
- Eligible Denominator Population

Parking Lot (items for next time):

- *Measurement Periods*
- *Measure Specifications*
- *Goal Calculation*

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Category C Overview

- Category C builds on pay-for-performance quality measures from Category 3 in DY2-DY6.
- Hospitals and physician practices will select Measure Bundles from the Measure Bundle Menu.
  - Measure Bundles have both required and optional measures.
- CMHCs will select measures from the CMHC Menu.
- LHDs will select measures from the LHD Menu.

Category C & MPT

Measure Selection

- Hospitals and physician practices must select Measure Bundles worth enough points to meet the Minimum Point Threshold (MPT).
- CMHCs and LHDs must select measures worth enough points to meet the MPT.

Hospital & Physician Practice
Bundle Development Process

- Measure Bundles align with common and successful project areas from DY2-6 as determined by the Clinical Champions in developing the Transformational Extension Menu.
- HHSC worked with Bundle Advisory Teams (BATs) consisting of over 100 clinicians from across the state in a 6 week iterative consensus building process to develop the Measure Bundles.
- Measures were taken from existing common Category 3 measures from DY2-6, CMS Consensus and Core Sets, MACRA MIPS QPP measures, and measures submitted by BAT members.
- Most measures from the MCO P4Q Program are included in the Category C Measure Bundle Menu.

CMHC & LHD
Menu Development Process

- HHSC worked with the Texas Council of Community Centers, CMHC providers, and LHD providers to develop the list of measures for the CMHC and LHD Menus.
- Where possible, HHSC encourages alignment of measures across the Measure Bundles, CMHC, and LHD Menus.
- *Both CMHCs and LHDs may request in the stakeholder feedback survey to add specific measures from the Measure Bundle Menu to the CMHC or LHD menus as appropriate.*

Measure Overview

- There are 144 measures in the draft menu.
- All measures are P4P unless specified as an innovative measure.
- Some measures are included in multiple bundles.
- Some measures are included in both the Hospital and Physician Practice Measure Bundle Menu and the CMHC or LHD menus.
- Specifications will be updated for DY7/DY8.

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Measure Points

Each measure is assigned a point value based on the following criteria:

Points	Description
3 Points	Patient clinical measures for which improvement in the measure represents an improvement in patient health outcomes or utilization patterns. (Most measures that were standalone measures in DY2-6 will be 3-point measures in DY7-8)
2 Points	Cancer screening measures and hospital safety and infection measures
1 Point	Measures of clinical practice, immunization rates, and measures related to quality of life or functional assessment
0 Points	Innovative measure that are pay-for-reporting (P4R)

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Hospital & Physician Practice
Measure Bundle Base Point Value

- The base point value of a Measure Bundle is determined by adding the points for the required measures in the Measure Bundle.
- Some bundles are designated a "*High State Priority*" or a "*State Priority*" which results in an increase to the base point value.
  - High State Priority are multiplied by 2.
  - State Priority are multiplied by 1.5.
- State priority bundles align with HHSC Medicaid/CHIP quality strategies.

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Hospital & Physician Practice
Additional Points

- Certain optional measures in a Measure Bundle, if selected, add points to the Measure Bundle.
  - Measures that add additional points are most optional 3-point measures and measures that align with state priorities.
- Optional measures that add points, if selected, are not impacted by a High State Priority or a State Priority Multiplier.

Hospital & Physician Practice
Base Point Value Example

E1 Improved Maternal Care

ID	Measure	Required	Required Measure Points	Additional Points
E1-148	PC-01 Elective Delivery	N		
E1-150	PC-02 Cesarean Section	Y	1	
E1-151	PC-03 Antenatal Steroids	N		
E1-193	Contraceptive Care – Postpartum Women Ages 15–44	N		+1
E1-232	Timeliness of Prenatal Care	Y	1	
E1-235	Post-Partum Follow-Up and Care Coordination	Y	3	
E1-300	Behavioral Health Risk Assessment	Y	1	
E1-378	Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section.	N		
TBD	*Innovative Measure Under Consideration: Preeclampsia or OB Hemorrhage measure*	N		

- Bundle points are calculated as sum of required points times 2 for a high state priority (6 X 2 = 12)
- Selecting bundle E1 counts as 12 points towards MPT, or 13 points if selected with optional measure E1-193

Hospital & Physician Practice Measure Bundles (A1 – D4)

Bundle ID	Hospital & Physician Practice Measure Bundles	Base Points	Possible Addition-al Points	Max Possible Points
A1	Improved Chronic Disease Management: Diabetes Care [State Priority (SP)]	12	3	15
A2	Improved Chronic Disease Management: Heart Disease (SP)	12	3	15
B1	Care Transitions & Hospital Readmissions	6	-	6
B2	Patient Navigation & ED Diversion	4	3	7
C1	Primary Care Prevention - Healthy Texans (SP)	9	-	9
C2	Primary Care Prevention - Cancer Screening & Follow-Up	6	3	9
C3	Hepatitis C	5	-	5
D1	Pediatric Primary Care (SP)	12	1	13
D3	Pediatric Hospital Safety	6	-	6
D4	Pediatric Chronic Disease Management: Asthma (SP)	11	3	14

Hospital & Physician Practice Measure Bundles (E1 – J1)

Bundle ID	Hospital & Physician Practice Measure Bundles	Base Points	Possible Addition-al Points	Max Possible Points
E1	Improved Maternal Care [High State Priority (HSP)]	12	1	13
F1	Improved Access to Adult Dental Care	6	-	6
F2	Preventive Pediatric Dental	2	-	2
G1	Palliative Care	6	-	6
H1	Integration of Behavioral Health in a Primary Care Setting (SP)	8	-	8
H2	Behavioral Health and Appropriate Utilization (SP)	9	6	15
H3	Chronic Non-Malignant Pain Management (HSP)	4	3	7
H4	Integrated Care for People with Serious Mental Illness (SP)	3	-	3
I1	Specialty Care	2	-	2
J1	Hospital Safety	8	-	8

Hospital & Physician Practice Minimum Bundle Selection Requirement

- A hospital or physician practice with a total valuation (all categories) of more than $2,000,000 per DY must either:
  - Select at least one Bundle with at least one required 3 point measure, or
  - Select at least one Bundle with at least one optional 3 point measure selected.

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Hospital & Physician Practice
Minimum Bundle Selection 1

- The following can only be selected in addition to a bundle with a required or selected optional 3-point measure:
  - C1: Healthy Texans
  - C3: Hepatitis C
  - D3: Pediatric Hospital Safety
  - F2: Preventive Pediatric Dental
  - G1: Palliative Care
  - H4: Integrated Care of People with Serious Mental Illness
  - I1: Specialty Care
  - J1: Hospital Safety

Hospital & Physician Practice Minimum Bundle Selection Example 1

C1: Primary Care & Prevention – Health Texans

- No required or optional 3-point measures
- Does not meet minimum selection requirement and must be selected along with a Bundle with a 3-point measure.

ID	Measure	Required	Required Measures Points	Additional Points
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Y	1	
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Y	1	
C1-147	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Y	1	
C1-268	Pneumonia vaccination status for older adults	Y	1	
C1-269	Preventive Care and Screening: Influenza Immunization	Y	1	
C1-272	Adults (18+ years) Immunization status	Y	1	
C1-280	Chlamydia Screening in Women (CHL)	N		
C1-285	Advance Care Plan	N		
C1-389	Human Papillomavirus Vaccine (age 14 -26)	N		

Hospital & Physician Practice
Minimum Bundle Selection 2

- The following have a required 3-point measure and count towards minimum bundle selection requirement:
  - A1: Diabetes Care
  - A2: Heart Disease
  - B1: Care Transitions & Hospital Readmissions
  - B2: Patient Navigation & ED Diversion
  - D1: Pediatric Primary Care
  - D4: Pediatric Asthma
  - E1: Improved Maternal Care
  - F1: Adult Dental
  - H1: Integration of BH in a Primary or Specialty Care Setting
  - H2: BH and Appropriate Utilization

Hospital & Physician Practice Minimum Bundle Selection Example 2

A1: Diabetes Care

- Has a required 3-point measure
- Meets minimum bundle selection requirement

ID	Measure	Required	Required Measures Points	Additional Points
A1-111	Comprehensive Diabetes Care: Eye Exam (retinal) performed	N		
A1-112	Comprehensive Diabetes Care: Foot Exam	Y	1	
A1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	N		
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Y	3	
A1-116	Comprehensive Diabetes Care: Medical Attention for Nephropathy	N		
A1-207	Diabetes care: BP control (<140/90mm Hg)	Y	3	
A1-208	Comprehensive Diabetes Care LDL-C Screening	Y	1	
A1-247	Reduce Emergency Department visits for Diabetes	N		+3
A1-321	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	N		

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Hospital & Physician Practice
Minimum Bundle Selection 3

- The following have an optional 3-point measure that count towards the minimum bundle selection requirement if the optional 3-point measure is selected:
  - C2: Cancer Screening & Follow Up
    - Must select optional measure C2-274: Mammography follow-up rate
  - H3: Chronic Non-Malignant Pain Management
    - Must select optional measure H3-197: Use of Opioids at High Dosage

Hospital & Physician Practice Minimum Bundle Selection Example 3

C2: Primary Care Prevention: Cancer Screening

- Optional 3-point measure
- Meets minimum bundle selection requirement if optional 3-point measure is selected

ID	Measure	Required	Required Measures Points	Addi-tional Points
C2-106	Cervical Cancer Screening	Y	2	
C2-107	Colorectal Cancer Screening	Y	2	
C2-162	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	N		
C2-186	Breast Cancer Screening	Y	2	
C2-199	PQRS #439: Age Appropriate Screening Colonoscopy	N		
C2-274	Mammography follow-up rate	N		+3
C2-275	Abnormal Pap test follow-up rate	N		

Hospital & Physician Practice
Measure Bundles (K1 – K2)

Bundle ID	Hospital & Physician Practice Measure Bundles	Base Points	Possible Addition-al Points	Max Possible Points
K1	Rural Preventative Care	3	4	7
K2	Rural Emergency Care	3	-	3

- K1 and K2 can only be selected by hospitals with a total valuation (All Categories) at or below $2,000,000 per DY.
- Hospitals with a total valuation below $2,000,000 may select bundles in addition to K1 or K2.

Hospital & Physician Practice Minimum Bundle Valuation

- Providers have flexibility in distributing valuation among Measure Bundles.
- Each selected Measure Bundle has a minimum valuation based on the point value of the Measure Bundle and the total point value of all selected Measure Bundles.
- Measure Bundles without a 3-point measure (required or selected) have a maximum valuation.
- Measure Bundles with at least one 3-point measure selected have no maximum valuation.

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Hospital & Physician Practice
Bundle Valuation Calculations

Where:

A = Measure Bundle Point Value

B = The sum of all selected Measure Bundles Point Values

C = Category C valuation

Minimum Measure Bundle Valuation:

*(A/B)/2 * C*

Maximum Measure Bundle Valuation for bundles with no 3-point measure selected:

*(A/B) * C*

Hospital & Physician Practice
Valuation Example (Pt 1)

- Performing Provider: Hospital, with inpatient and outpatient
- Total Valuation per DY: $20,000,000
- Hospital's MPT: 40 points

  ($20,000,000 / $500,000)
- Category C Valuation in DY7: $11,000,000

  (RHP met private hospital participation requirements so Cat D at 15% and Cat C at 55%; $20,000,000 x .55)

Hospital & Physician Practice
Valuation Example (Pt 2)

Bundle Selections	Selected Bundle Required Points + Additional Points	Min DY7 Valuation	Max DY7 Valuation	DY7 Selected Valuation
A1 Improved Chronic Disease Management: Diabetes Care	12	(12 / 40) / 2 *$11,000,000 = $1,650,000	NA	$4,850,000
B1 Care Transitions & Hospital Readmissions	6	(6 / 40) / 2 * $11,000,000 = $825,000	NA	$825,000
C1 Primary Care Prevention - Healthy Texans (no 3-point measures)	9	(9 / 40) / 2 * 11,000,000 = $1,237,500	(9 / 40) * $11,000,000 = $2,475,000	$1,800,000
E1 Improved Maternal Care	12 + 1	(13 / 40) / 2 * $11,000,000 = $1,787,500	NA	$3,525,000
Total	40 points (meets MPT)			$11,000,000

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Hospital & Physician Practice
Bundle Valuation Details

- Measure Bundle valuation as a percentage of a provider's Category C valuation will be consistent across measurement years.
  - EXAMPLE: Bundle A will be 20% of Cat C valuation in DY7 and DY8. Bundle C cannot be 15% of Cat C in DY7 and 30% of Cat C in DY8.
- Each Measure in a Measure Bundle is equally valued, with some exceptions for measures with low volume.

Hospital & Physician Practice Exceptions for Limited Scope of Practice

- Exceptions to the MPT and bundled selection may be available for providers with a limited scope of practice such as children's hospitals, infectious disease hospitals, and Institutes of Mental Disease.
- Providers with a limited scope of practice may submit an exception request to HHSC prior to RHP plan submission. The submission date for such requests is currently TBD.
- Requests may be subject to review by CMS and if approved may result in a reduced valuation.

CMHC & LHD
Measure Selection Requirements

- CMHCs and LHDs will select measures rather than measure bundles.
- CHMCs and LHDs must select at least one 3-point measure.

- Exception for depression response measure: If a CMHC selects more than one of the depression response measures M1-165, M1-181, or M1-286, only 3 points will be counted towards the Performing Provider's MPT.

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CMHC & LHD
Measure Valuation

- CMHC and LHD providers have flexibility in distributing valuation among measures.
- All measures have a minimum valuation.
- Measures that are 1-point or 2-point measures have a maximum valuation.

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CMHC & LHD
Measure Valuation Calculations

Where:

C = Total Category C valuation

D = Number of Measures Selected

Minimum Measure Valuation:

(C/D)/2

Maximum measure valuation for 1-point and 2-point measures:

(C/D)

CMHC & LHD
Valuation Example (Pt 1)

- Performing Provider Type: CMHC
- Total Valuation per DY: $7,500,000
- CMHC's MPT: 15 points

  ($7,500,000 / $500,000)
- Category C Valuation in DY7: $4,125,000

  (RHP met private hospital participation requirements so Cat D at 15% and Cat C at 55%; $4,125,000 x .55)

CMHC & LHD
Valuation Example (Pt 2)

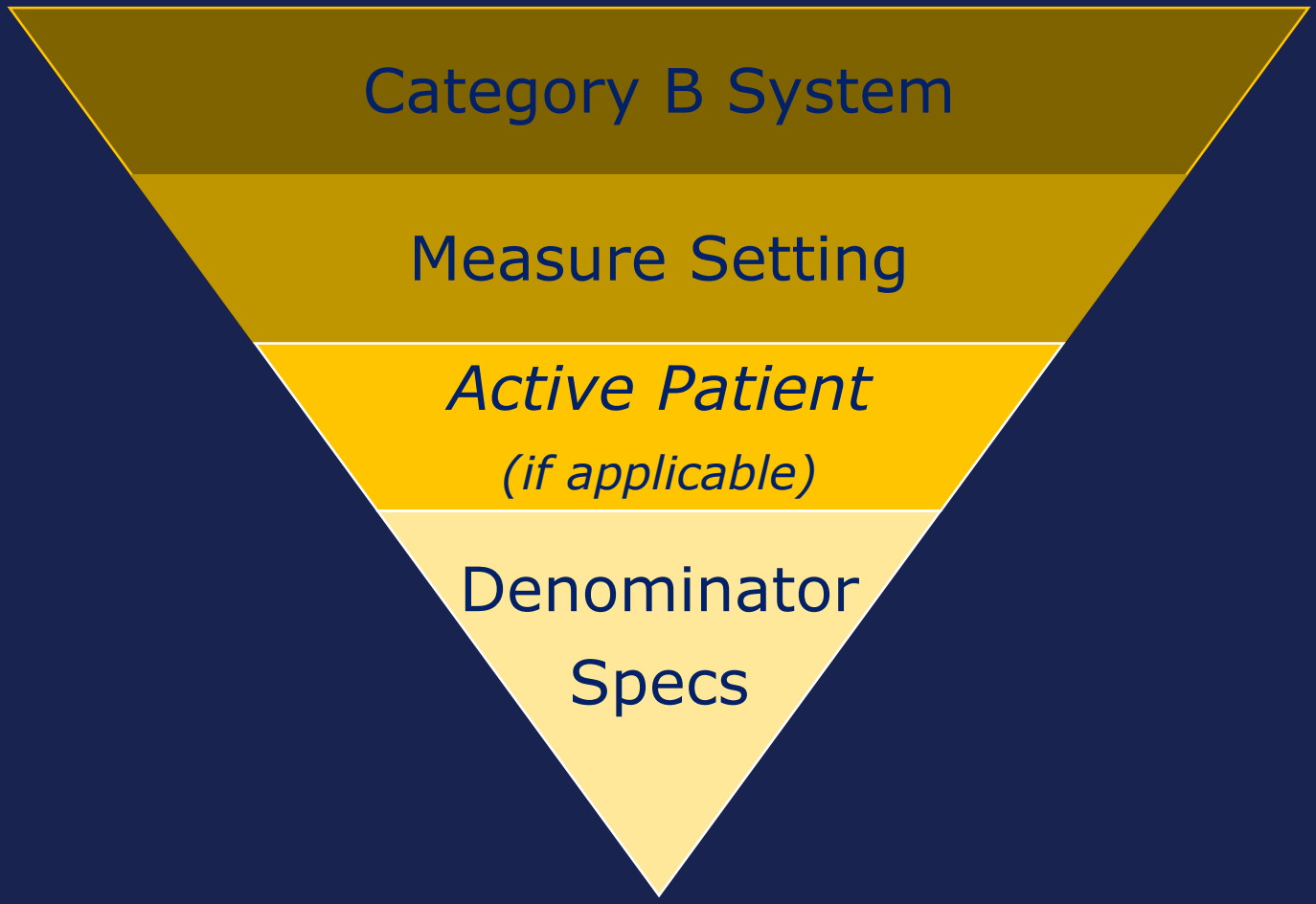
Measure Selection	Points	Min DY7 Valuation	Max DY7 Valuation	DY7 Example Valuation
M1-165: Depression Remission at 12 Months	3	($4,125,000/10)/2 =$206,250	N/A	$450,000
M1-181: Depression Response at 12 Months- Progress Towards Remission	(3)*		N/A	$650,000
M1-241: Decrease in MH admissions to criminal justice settings	3		N/A	$550,000
M1-257: Care Planning for Dual Diagnosis	1		($4,125,000/10) =$412,500	$300,000
M1-259: Assignment of PCP to Individuals with Schizophrenia	1			$250,000
M1-260: Annual Physical Exam for Persons with Mental Illness	1			$362,500
M1-265: Housing Assessment for Individuals with Schizophrenia	1			$206,250
M1-340: Substance use disorders	1			$343,750
M1-342: Time to Initial Evaluation	1			$412,500
M1-387: Reduce ED visits for BH and Substance Abuse	3		N/A	$600,000
TOTAL	**15 points** (met MPT)			$4,125,000

*M1-181 does not count towards MPT but functions like a 3-point measure for valuation

Eligible Denominator Population

- The eligible denominator population for each measure will be determined by
  - the measure setting assigned to each measure,
  - active patient definition if applicable,
  - and the denominator specifications.
- Measures within a bundle may have different settings
  - Example: A1: Diabetes Care
    - A1-112 HbA1c Testing, primary care setting
    - A1-247 ED Visits for Diabetes, ED setting

Measure Specific Denominator Population



Active Patient – Primary Care

- For measures with a primary care setting
  - Individuals that meet any one of the following criteria:
    - Two visits in the 12-month measurement period
    - One visit in the 12-month measurement period and one visit in the 12 months prior to the measurement period
    - Assigned to a primary care physician

Active Patient – Specialty Care

- For measures with an outpatient specialty care setting, providers will propose an active patient definition for each specialty included in a measure bundle as part of the RHP Plan Update.
- Some measures will be reported for both primary and specialty care settings as a combined rate.
  - Example: H1-146 Screening for Clinical Depression & Follow-Up Plan may apply to a primary care setting, as well as optional outpatient specialty care settings such as endocrinology and orthopedics.

Denominator Example (Pt 1)

H1: Integration of BH in a Primary and Specialty Care Setting

H1-146: Screening for Clinical Depression & Follow-Up Plan

1. System: The provider's system definition includes primary care clinics and outpatient specialty care clinics
2. Setting: Primary care clinics and outpatient specialty care clinics appropriate for bundle, in this case Endocrinology and Orthopedic
3. Active Patient: In each measurement period, the provider would identify individuals that meet the active patient definition in each setting
4. Denominator Specifications: From those individuals, the denominator would be determined following measure specifications

Denominator Example (Pt 2)

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H1-146: Screening for Clinical Depression & Follow-Up Plan

- Provider will report the baseline rate for individuals that meet the denominator criteria for the measure stratified by payer type (all-payer, Medicaid, and LIU)
- Based on the combined MLIU rate for the baseline (with some exceptions) , goals will be set for DY7 and DY8 achievement milestones.
- Provider will follow same steps to report PY1 and PY2. Note, the active patient population will change each year.

Category C Compendium of Measure Specifications

- The following items will be included in the Category C Compendium of Measure Specifications:
  - Settings for each measure
  - Measures identified as QISMC or IOS
  - Benchmarks if QISMC
  - Exceptions to measurement periods for certain measures (example: NQF 0041 Influenza Immunization)
  - Measures that are not eligible for a 6-month baseline
  - Complete draft expected in July/August

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Hospital & Physician Practice
Innovative Measures

- During the Measure Bundle development process, some innovative measures were identified for inclusion in the Measure Bundles.
- HHSC is currently working with potential measure stewards for innovative measures in the Bundles D1, H1, and H3.
- HHSC is seeking a measure steward for the proposed innovative measure related to oral cancer screening in Bundle F1: Improved Access to Adult Dental Care.

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Category D

Category D

Statewide Reporting Measure Bundle

- Population-focused improvements.
- Providers required to report according to type of provider.
- Similar to previous Category 4 with additional measures developed for non-hospital providers.

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Next Steps

Estimated Timeline

- Through July 7, 2017 – Gather stakeholder feedback on the draft Measure Bundle Protocol using the survey posted on the waiver website. HHSC is particularly interested in feedback on Category D measures.
- Late July 2017 – Submit Measure Bundle Protocol to CMS for approval, including any updates to the PFM based on the Measure Bundle Protocol.

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Estimated Timeline (cont.)

- July/August – release of full draft of Category C Compendium of Measure Specifications
- August 2017 – DY7-8 proposed rules posted for public comment.
- August/September 2017 – Targeted CMS approval of protocols.
- January 31, 2018 – Anchors submit RHP Plan Updates.

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Thank you

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Website:

https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver